

2005 HealthSelect and CIGNA HMO Benefit Comparison Grid Summary

	HealthSelect HIGH Option	HealthSelect LOW Option	CIGNA HMO HIGH Option	CIGNA HMO LOW Option
	In-Network Services Only	In-Network Services Only	In-Network Services Only; Restricted to CIGNA Clinics	In-Network Services Only; Restricted to CIGNA Clinics
Standard Benefit Coverage				
Deductible				
Individual	None	None	None	None
Family	None	None	None	None
Standard Coinsurance % Covered by Plan	None	None	None	None
Out-of-Pocket Maximum (OOP)				
Individual	None	\$5,000 OOP Maximum for inpatient & outpatient facility copay	None	\$5,000 OOP Maximum for inpatient & outpatient facility copay
Family	None	\$10,000 OOP Maximum for inpatient & outpatient facility copay	None	\$10,000 OOP Maximum for inpatient & outpatient facility copay
Lifetime Maximum Benefit	None	None	None	None
Pre-existing Condition Limitation	None	None	None	None
General Services				
Primary Care Physician Services	\$10 Copay	\$25 Copay	\$10 Copay	\$25 Copay
Specialty Care Physician Services	\$10 Copay	\$45 Copay	\$10 Copay	\$45 Copay
Independent Lab & X-Ray Facility	No Copay for lab or x-ray; \$25 Copay for MRI, PET & CT Scans	No Copay for lab or x-ray; \$100 Copay for MRI, PET & CT Scans	No Copay for lab or x-ray; \$50 Copay for MRI, PET & CT Scans	No Copay for lab or x-ray; \$100 Copay for MRI, PET & CT Scans
Outpatient Surgery	No Copay	\$250 Copay, then covered at 90%	No Copay	\$250 Copay, then covered at 90%
Urgent Care Facility (Participating)	\$25 Copay if urgent, otherwise not covered	\$50 Copay if urgent, otherwise not covered	\$35 Copay if urgent, otherwise not covered	\$50 Copay if urgent, otherwise not covered
Emergency Room (Copay Waived if Admitted)	\$50 Copay if emergency, otherwise not covered	\$100 Copay if emergency, otherwise not covered	\$75 Copay if emergency, otherwise not covered	\$100 Copay if emergency, otherwise not covered
Ambulance	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered
Inpatient Hospitalization				
Facility Services	No Copay	\$500 Copay, then covered at 90%	No Copay	\$500 Copay, then covered at 90%
Physician & Surgeon's Services	No Copay	No Copay	No Copay	No Copay
Penalty for Not Getting Prior Authorization	None	None	None	None
Maternity				
Prenatal & Postnatal Exams	Copay waived after 1st visit	Copay waived after 1st visit	Copay waived after 1st visit	Copay waived after 1st visit
Hospital Delivery	No Copay	\$500 Copay; then covered at 90%	No Copay	\$500 Copay; then covered at 90%
Equipment & Devices				
Durable Medical Equipment	No Copay (\$2,000 maximum)	No Copay (\$3,500 maximum)	No Copay (\$3,500 maximum)	No Copay (\$3,500 maximum)
External Prosthetics & Orthotics	No Copay (\$2,000 maximum)	\$200 deductible (\$1,000 maximum)	No Copay (\$3,000 maximum)	\$200 deductible (\$1,000 maximum)
Outpatient Rehabilitation				
Physical, Speech, & Occupational Therapy	\$10 Copay; 60 visits combined maximum/year	\$45 Copay; 60 visits combined maximum/year	\$10 Copay; 60 visits combined maximum/year	\$45 Copay; 60 visits combined maximum/year
Chiropractic Services (chronic care not covered; must be medically necessary).	\$10 Copay 12 self-referral visits/year	\$45 Copay; 20 self-referral visits/year	\$10 Copay 20 self-referral visits/year	\$45 Copay; 20 self-referral visits/year
Alternative Medicine; uses designated network	\$5 Copay; 12 Self-referral visits/year	\$5 Copay; 12 Self-referral visits/year	\$5 Copay; 10 Self-referral visits/year	\$5 Copay; 10 Self-referral visits/year
Other Healthcare Facilities				
Skilled Nursing Facilities				
Subscriber Payment	No Copay	Covered at 90%	No Copay	Covered at 90%
Limit per Contract Year	60 days per year	60 days per year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
Home Health Care	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)
Family Planning				
Sterilization				
Vasectomy	Place of Service Copay	Place of Service Copay	Place of Service Copay	Place of Service Copay
Tubal Ligation	Place of Service Copay	Place of Service Copay	Place of Service Copay	Place of Service Copay
Infertility Services	Place of Service Copay; Diagnostic Services & Corrective Treatment Only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only

2005 HealthSelect and CIGNA HMO Benefit Comparison Grid Summary

Pharmacy Benefit Choices through Walgreens Health Initiatives				
You choose either the Coinsurance Rx Plan or the Consumer Choice Rx Plan				
Coinsurance Rx Plan			Consumer Choice Rx Plan	
Pharmacy	Medication	Copay		
Retail (30-day supply)	Generic	25% of contract rate (minimum \$2, maximum \$12)	Level I Pharmacy Account	The account is funded 100% by Maricopa County at \$200/individual or \$400/family. Use this amount to pay for prescription costs as you choose, and there is no copay. This plan does not have an approved drug list (formulary) but certain drugs require prior authorization or use of certain medications in a specific order (step therapy). Quantity level limits apply to certain medications, & some drug classes, such as infertility & cosmetic medications, are excluded. Any unused portion is rolled over to the next benefit year. Amounts spent from the pharmacy account do not accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	30% of contract rate (minimum \$5, maximum \$30)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$20)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$20)		
	Non-preferred specialty drugs	\$50 Copay		
	Generic	25% of contract rate (minimum \$6; maximum \$36)		
Advantage 90 (90-day supply)	Preferred Brand Name	30% of contract rate (minimum \$15; maximum \$90)	Level II Employee Responsibility	You are responsible for the deductible, which begins after you have exhausted the funds in the Pharmacy account and is funded 100% by you at the rate of \$200/individual or \$400/ family. You spend your deductible amount toward your prescription costs as you choose. If you have enrolled in the Mariflex flexible spending account, you can use your pre-taxed funds to pay for medication costs in this level. Amounts spent towards the deductible accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)		
	Non-preferred specialty drugs	Not available in more than 30-day supply		
	Generic	15% of contract rate (minimum \$6, maximum \$28)		
	Preferred Brand Name	25% of contract rate (minimum \$15, maximum \$70)		
Mail Order (90-day supply)	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)	Level III Insurance	The insurance level covers the cost of the medication at 80% of the discounted cost of the medication. You pay 20%. Amounts spent as coinsurance accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)		
	Non-preferred specialty drugs	\$50 for 30-day supply through home delivery service	Level IV Specialty Medication	Specialty pharmacy medications will not be charged against your pharmacy account or deductible. Instead, a \$50 copayment will be charged. The out-of-pocket expense will be applied toward out-of-pocket maximums. Amounts spent as copayments for specialty medications accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
Pharmacy Out-of-Pocket Maximum (OOP)	\$1,500 Individual/\$3,000 Family Maximum per year		Pharmacy Out-of-Pocket Maximum (OOP)	\$1,500 Individual/\$3,000 Family Maximum per year
Behavioral Health Benefit	United Behavioral Health for all medical plans			
Vision Benefit	AVESIS Vision Plan for all medical plans			
Dependent Children Eligibility	Child must be unmarried and legally/financially dependent upon employee and/or spouse. Covered to age 19 unless full time student & then covered to age 25			

The plan documents under links on the Benefits Home page, located at www.maricopa.gov/benefits or ebc.maricopa.gov/hr/benefits, provide a complete description of benefits. These official documents govern if there is a discrepancy between the information on this comparison spreadsheet & the plan documents.

2005 POS (Point of Service) Benefit Comparison Grid Summary

	CIGNA POS HIGH Option	CIGNA POS HIGH Option	CIGNA POS LOW Option	CIGNA POS LOW Option
	<u>In-Network Services</u>	<u>Out-of-Network Services</u>	<u>In-Network Services</u>	<u>Out-of-Network Services</u>
Standard Benefit Coverage				
Deductible				
Individual	None	\$300	None	\$1,000
Family	None	\$600	None	\$2,000
Standard Coinsurance % Covered by Plan	None	70% of Reasonable & Customary Charges	None	70% of Reasonable & Customary Charges
Out-of-Pocket Maximum (OOP)				
Individual	\$900 OOP Maximum for inpatient & outpatient facility copays	\$3,000 OOP Maximum for inpatient & outpatient facility deductibles	\$5,000 OOP Maximum for inpatient & outpatient facility copays	\$10,000 OOP Maximum for inpatient & outpatient facility deductibles
Family	\$1,800 OOP Maximum for inpatient & outpatient facility copays	\$6,000 OOP Maximum for inpatient & outpatient facility deductibles	\$10,000 OOP Maximum for inpatient & outpatient facility copays	\$20,000 OOP Maximum for inpatient & outpatient facility deductibles
Lifetime Maximum Benefit	None	\$5 Million	None	\$1 Million
Pre-existing Condition Limitation	None	12 months waiting period; creditable coverage months may decrease the period	None	12 months waiting period; creditable coverage months may decrease the period
General Services				
Primary Care Physician Services	\$15 Copay	70% after deductible; preventive care covered in-network only	\$35 Copay	70% after deductible; preventive care covered in-network only
Specialty Care Physician Services	\$25 Copay	70% after deductible; preventive care covered in-network only	\$50 Copay	70% after deductible; preventive care covered in-network only
Independent Lab and X-Ray Facility	No Copay for lab or x-ray; \$50 Copay for MRI, PET & CT Scans	70% after deductible	No Copay for lab or x-ray \$200 Copay for MRI, PET & CT Scans	70% after deductible
Outpatient Surgery	\$100 Copay	70% after deductible	\$500 Copay, then covered at 90%	\$1,000/visit deductible & plan deductible, then covered at 70%
Urgent Care Facility	\$50 Copay if urgent, otherwise 70% after deductible	\$50 Copay if urgent, otherwise 70% after deductible	\$75 Copay if urgent, otherwise 70% after deductible	\$75 Copay if urgent, otherwise 70% after deductible
Emergency Room (Copay Waived if Admitted)	\$100 Copay if emergency, otherwise 70% after deductible	\$100 Copay if emergency, otherwise 70% after deductible	\$150 Copay if emergency, otherwise 70% after deductible	\$150 Copay if emergency, otherwise 70% after deductible
Ambulance	No Copay if emergency, otherwise 70% after deductible	No Copay if emergency, otherwise 70% after deductible	No Copay if emergency, otherwise 70% after deductible	No Copay if emergency, otherwise 70% after deductible
Inpatient Hospitalization				
Facility Services	\$100/day, \$300 maximum/admission	70% after deductible	\$1,000 Copay, then covered at 90%	\$2,000/admission deductible plus plan deductible, then covered at 70%
Physician & Surgeon's Services	No Copay	70% after deductible	No Copay	70% after deductible
Penalty for Not Getting Prior Authorization	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services
Maternity				
Prenatal & Postnatal Exams	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	70% after deductible
Hospital Delivery	\$100/day, \$300 maximum/admission	70% after deductible	\$1,000 Copay, then covered at 90%	\$2,000 deductible and plan deductible, then covered at 70%
Equipment & Devices				
Durable Medical Equipment	No Copay (\$3,500 maximum)	Covered in-network only	No Copay (\$3,500 maximum)	Covered in-network only
External Prosthetics & Orthotics	No Copay (\$3,000 maximum)	Covered in-network only	\$200 deductible (\$1,000 maximum)	Covered in-network only
Outpatient Rehabilitation				
Physical, Speech, & Occupational Therapy	\$15 Copay; 60 visits combined maximum/year	70% after deductible; 60 visits combined maximum/year	\$50 Copay; 60 visits combined maximum/year	70% after deductible; 60 visits combined maximum/year
Chiropractic Services (chronic care not covered; must be medically necessary).	\$15 Copay 20 self-referral visits/year	Covered in-network only	\$50 Copay 20 self-referral visits/year	Covered in-network only
Alternative Medicine; uses designated network	\$5 Copay; 10 Self-referral visits/year	Covered in-network only	\$5 Copay; 10 Self-referral visits/year	Covered in-network only
Other Healthcare Facilities				
Skilled Nursing Facilities				
Subscriber Payment	No Copay	70% after deductible	90% coinsurance after deductible	70% after deductible
Limit per Contract Year	90 days per year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
Home Health Care	No Copay when medically necessary (unlimited)	70% after deductible; 40 days/year	No Copay when medically necessary (unlimited)	70% after deductible; 40 days per year
Family Planning				
Sterilization				
Vasectomy	Place of Service Copay	70% after deductible	Place of Service Copay	70% after deductible
Tubal Ligation	Place of Service Copay	70% after deductible	Place of Service Copay	70% after deductible
Infertility Services	PCP or Specialist Copay; Diagnostic Services & Corrective Treatment Only	Covered in-network only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only	Covered in-network only

2005 POS (Point of Service) Benefit Comparison Grid Summary

Pharmacy Benefit Choices through Walgreens Health Initiatives				
You choose either the Coinsurance Rx Plan or the Consumer Choice Rx Plan				
Coinsurance Rx Plan			Consumer Choice Rx Plan	
Pharmacy	Medication	Copay		
Retail (30-day supply)	Generic	25% of contract rate (minimum \$2, maximum \$12)	Level I Pharmacy Account	The account is funded 100% by Maricopa County at \$200/individual or \$400/family. Use this amount to pay for prescription costs as you choose, and there is no copay. This plan does not have an approved drug list (formulary) but certain drugs require prior authorization or use of certain medications in a specific order (step therapy). Quantity level limits apply to certain medications, & some drug classes, such as infertility & cosmetic medications, are excluded. Any unused portion is rolled over to the next benefit year. Amounts spent from the pharmacy account do not accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	30% of contract rate (minimum \$5, maximum \$30)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$20)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$20)		
	Non-preferred specialty drugs	\$50 Copay		
Advantage 90 (90-day supply)	Generic	25% of contract rate (minimum \$6; maximum \$36)	Level II Employee Responsibility	You are responsible for the deductible, which begins after you have exhausted the funds in the Pharmacy account and is funded 100% by you at the rate of \$200/individual or \$400/ family. You spend your deductible amount toward your prescription costs as you choose. If you have enrolled in the Mariflex flexible spending account, you can use your pre-taxed funds to pay for medication costs in this level. Amounts spent towards the deductible accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	30% of contract rate (minimum \$15; maximum \$90)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)		
	Non-preferred specialty drugs	Not available in more than 30-day supply		
Mail Order (90-day supply)	Generic	15% of contract rate (minimum \$6, maximum \$28)	Level III Insurance	The insurance level covers the cost of the medication at 80% of the discounted cost of the medication. You pay 20%. Amounts spent as coinsurance accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	25% of contract rate (minimum \$15, maximum \$70)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)		
	Non-preferred specialty drugs	\$50 for 30-day supply through home delivery service		
Pharmacy Out-of-Pocket Maximum	\$1,500 Individual/\$3,000 Family Maximum per year		Pharmacy Out-of-Pocket Maximum	\$1,500 Individual/\$3,000 Family Maximum per year
Behavioral Health Benefit	United Behavioral Health for all medical plans			
Vision Benefit	AVESIS Vision Plan for all medical plans			
Dependent Children	Child must be unmarried and legally/financially dependent upon employee and/or spouse. Covered to age 19 unless full time student & then covered to age 25			

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2005 PPO (Preferred Provider Organization) Benefit Comparison Grid Summary

	CIGNA PPO HIGH Option	CIGNA PPO HIGH Option	CIGNA PPO LOW Option	CIGNA PPO LOW Option
	<u>In-Network Services</u>	<u>Out-of-Network Services</u>	<u>In-Network Services</u>	<u>Out-of-Network Services</u>
Standard Benefit Coverage				
Deductible				
Individual	\$250	\$750	\$1,100	\$1,100
Family	\$500	\$1,500	\$2,200	\$2,200
Standard Coinsurance % Covered by Plan	80% of contracted rate	60% of Reasonable & Customary Charges	80% of contract rate	60% of Reasonable & Customary Charges
Out-of-Pocket Maximum (OOP)				
Individual	\$2,000 OOP Maximum applies to coinsurance	\$4,000 OOP Maximum applies to coinsurance	\$5,000 OOP Maximum applies to coinsurance	\$5,000 OOP Maximum applies to coinsurance
Family	\$6,000 OOP Maximum applies to coinsurance	\$12,000 OOP Maximum applies to coinsurance	\$10,000 OOP Maximum applies to coinsurance	\$10,000 OOP Maximum applies to coinsurance
Lifetime Maximum Benefit	None	\$5 Million	\$5 Million	\$5 Million
Pre-existing Condition Limitation	12 months waiting period; creditable coverage months may decrease the period	12 months waiting period; creditable coverage months may decrease the period	12 months waiting period; creditable coverage months may decrease the period	12 months waiting period; creditable coverage months may decrease the period
General Services				
Primary Care Physician Services	80% after deductible	60% after deductible; preventive care covered in-network only	80% after deductible	60% after deductible; preventive care covered in-network only
Specialty Care Physician Services	80% after deductible	60% after deductible; preventive care covered in-network only	80% after deductible	60% after deductible; preventive care covered in-network only
Independent Lab and X-Ray Facility	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Urgent Care Facility	\$50 Copay; deductible waived	\$50 copay if urgent, deductible waived, otherwise 60% after deductible	80% after deductible	80% after deductible if urgent, otherwise 60%
Emergency Room (Copay Waived if Admitted)	\$100 Copay; deductible waived	\$100 Copay if emergency, deductible waived, otherwise 60% after deductible	80% after deductible	80% after deductible if emergency, otherwise 60%
Ambulance	90% after deductible	90% after deductible if emergency, otherwise 60% after deductible	80% after deductible	80% after deductible if emergency, otherwise 60% after deductible
Inpatient Hospitalization				
Facility Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physician & Surgeon's Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Penalty for Not Getting Prior Authorization	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services
Maternity				
Prenatal & Postnatal Exams	80% Coinsurance, waived after 1st visit	60% after deductible	80% after deductible	60% after deductible
Hospital Delivery	80% after deductible	60% after deductible; Precertification	80% after deductible	60% after deductible; Precertification required
Equipment & Devices				
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
External Prosthetics & Orthotics	80% after deductible (\$3,000 maximum)	60% after deductible (\$3,000 maximum)	80% after deductible	60% after deductible
Outpatient Rehabilitation				
Physical, Speech, & Occupational Therapy	80% after deductible; 60 visits combined maximum/year	60% after deductible; 60 visits combined maximum/year	80% after deductible; 60 visits combined maximum/year	60% after deductible; 60 visits combined maximum/year
Chiropractic Services (chronic care not covered; must be medically necessary).	80% after deductible; unlimited	60% after deductible; unlimited	80% after deductible; unlimited	60% after deductible; unlimited
Alternative Medicine; uses designated network	\$5 Copay; 10 Self-referral visits/year	Covered in-network only	\$5 Copay; 10 Self-referral visits/year	Covered in-network only
Other Healthcare Facilities				
Skilled Nursing Facilities				
Subscriber Payment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Limit per Contract Year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
Home Health Care	80% after deductible	60% after deductible; 40 days/year	80% after deductible	60% after deductible
Family Planning				
Sterilization				
Vasectomy	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Tubal Ligation	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Infertility Services	80% after deductible; Diagnostic Services & Corrective Treatment Only	60% after deductible; Diagnostic Services & Corrective Treatment Only	Not Covered	Not Covered

2005 PPO (Preferred Provider Organization) Benefit Comparison Grid Summary

Pharmacy Benefit Choices through Walgreens Health Initiatives				
You choose either the Coinsurance Rx Plan or the Consumer Choice Rx Plan				
Coinsurance Rx Plan			Consumer Choice Rx Plan	
Pharmacy	Medication	Copay		
Retail (30-day supply)	Generic	25% of contract rate (minimum \$2, maximum \$12)	Level I Pharmacy Account	The account is funded 100% by Maricopa County at \$200/individual or \$400/family. Use this amount to pay for prescription costs as you choose, and there is no copay. This plan does not have an approved drug list (formulary) but certain drugs require prior authorization or use of certain medications in a specific order (step therapy). Quantity level limits apply to certain medications, & some drug classes, such as infertility & cosmetic medications, are excluded. Any unused portion is rolled over to the next benefit year. Amounts spent from the pharmacy account do not accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	30% of contract rate (minimum \$5, maximum \$30)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$20)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$20)		
	Non-preferred specialty drugs	\$50 Copay		
Advantage 90 (90-day supply)	Generic	25% of contract rate (minimum \$6; maximum \$36)	Level II Employee Responsibility	You are responsible for the deductible, which begins after you have exhausted the funds in the Pharmacy account and is funded 100% by you at the rate of \$200/individual or \$400/ family. You spend your deductible amount toward your prescription costs as you choose. If you have enrolled in the Mariflex flexible spending account, you can use your pre-taxed funds to pay for medication costs in this level. Amounts spent towards the deductible accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	30% of contract rate (minimum \$15; maximum \$90)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)		
	Non-preferred specialty drugs	Not available in more than 30-day supply		
Mail Order (90-day supply)	Generic	15% of contract rate (minimum \$6, maximum \$28)	Level III Insurance	The insurance level covers the cost of the medication at 80% of the discounted cost of the medication. You pay 20%. Amounts spent as coinsurance accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	25% of contract rate (minimum \$15, maximum \$70)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)	Level IV Specialty Medication	Specialty pharmacy medications will not be charged against your pharmacy account or deductible. Instead, a \$50 copayment will be charged. The out-of-pocket expense will be applied toward out-of-pocket maximums. Amounts spent as copayments for specialty medications accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Non-preferred specialty drugs	\$50 for 30-day supply through home delivery service		
Pharmacy Out-of-Pocket Maximum	\$1,500 Individual/\$3,000 Family Maximum per year		Pharmacy Out-of-Pocket Maximum	\$1,500 Individual/\$3,000 Family Maximum per year
Behavioral Health Benefit	United Behavioral Health	United Behavioral Health	Cigna Behavioral Health	CIGNA Behavioral Health
Vision Benefit	AVESIS Vision Plan for all medical plans			
Dependent Children	Child must be unmarried and legally/financially dependent upon employee and/or spouse. Covered to age 19 unless full time student & then covered to age 25			

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